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AGREEMENT AS TO RESOLUTION OF CONCERNS

I understand that I am entering into a contractual relationship with Karen Lin, Resident, Jaspreet Kaur, Resident, Marissa Cruz, Resident, Laura Vandenberg, OD, Lauren Wasikowski, OD, Michael Chermak, OD, Daniel Ochs, OD, Jessica Mark, OD, Eric Fazio, OD, Brian Szabo, DO, Kayla Unsell, MD, James Jachimowicz, MD, Eric Areiter, MD, Matthew Donovan, MD, Arian Moses, MD, David Garruto, MD, T. Hunter Newsom, MD / Newsom Eye & Laser Center for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Karen Lin, Resident, Jaspreet Kaur, Resident, Marissa Cruz, Resident, Laura Vandenberg, OD, Lauren Wasikowski, OD, Michael Chermak, OD, Daniel Ochs, OD, Jessica Mark, OD, Eric Fazio, OD, Brian Szabo, DO, Kayla Unsell, MD, James Jachimowicz, MD, Eric Areiter, MD, Matthew Donovan, MD, Arian Moses, MD, David Garruto, MD, T. Hunter Newsom, MD / Newsom Eye & Laser Center.

Should I initiate or pursue a meritorious medical malpractice Karen Lin, Resident, Jaspreet Kaur, Resident, Marissa Cruz, Resident, Laura Vandenberg, OD, Lauren Wasikowski, OD, Michael Chermak, OD, Daniel Ochs, OD, Jessica Mark, OD, Eric Fazio, OD, Brian Szabo, DO, Kayla Unsell, MD, James Jachimowicz, MD, Eric Areiter, MD, Matthew Donovan, MD, Arian Moses, MD, David Garruto, MD, T. Hunter Newsom, MD / Newsom Eye & Laser Center for professional care, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialists in the same or similar Karen Lin, Resident, Jaspreet Kaur, Resident, Marissa Cruz, Resident, Laura Vandenberg, OD, Lauren Wasikowski, OD, Michael Chermak, OD, Daniel Ochs, OD, Jessica Mark, OD, Eric Fazio, OD, Brian Szabo, DO, Kayla Unsell, MD, James Jachimowicz, MD, Eric Areiter, MD, Matthew Donovan, MD, Arian Moses, MD, David Garruto, MD, T. Hunter Newsom, MD / Newsom Eye & Laser Center. Further, I agree that these physicians retained by me or on my behalf to be an expert witness will be a member in good standing of the medical specialty society to which Karen Lin, Resident, Jaspreet Kaur, Resident, Marissa Cruz, Resident, Laura Vandenberg, OD, Lauren Wasikowski, OD, Michael Chermak, OD, Daniel Ochs, OD, Jessica Mark, OD, Eric Fazio, OD, Brian Szabo, DO, Kayla Unsell, MD, James Jachimowicz, MD, Eric Areiter, MD, Matthew Donovan, MD, Arian Moses, MD, David Garruto, MD, T. Hunter Newsom, MD / Newsom Eye & Laser Center belongs. I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by that physician's specialty society.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions. In further consideration Karen Lin, Resident, Jaspreet Kaur, Resident, Marissa Cruz, Resident, Laura Vandenberg, OD, Lauren Wasikowski, OD, Michael Chermak, OD, Daniel Ochs, OD, Jessica Mark, OD, Eric Fazio, OD, Brian Szabo, DO, Kayla Unsell, MD, James Jachimowicz, MD, Eric Areiter, MD, Matthew Donovan, MD, Arian Moses, MD, David Garruto, MD, T. Hunter Newsom, MD / Newsom Eye & Laser Center also agrees to exactly the same previously referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting evidence of a frivolous or meritless claim.

Patient and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and patient agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

Date of Signature: ______________________

Patient Name: ______________________

Patient Signature : ______________________

NEWSOMEYE
You deserve NEWSOM EYES!

4211 US Highway 27 N, Sebring, FL 33870 (863) 385-1544
13904 N Dale Mabry Hwy, Suite 200, Tampa, FL 33618 (813) 908-2020
113 S. Armenia Ave., Tampa, FL 33609 (813) 908-2020
3165 N McMullen Booth Rd., A-1, Clearwater, FL 33761 (727) 788-3937
14543 Cortez Blvd #6065, Brooksville, FL 34613 (352) 596-4030
www.NEWSOMEYE.com

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

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Acknowledgement of Receipt

By signing this document, I acknowledge that I have reviewed and/or requested a copy of the patient paperwork packet of Newsom Eye. This packet includes the following:

Please circle YES (Y) or NO (N) to applicable questions below.

- **Financial Policy** – I have read and understand the Financial Policy and agree to meet all financial obligations.

- **Lifetime Authorization** (1st & 2nd Sections) – Medicare or Insurance Certification for Payment.
  - Do you belong to a Health Maintenance Organization (HMO)? **Y N**
  - Do you need approval for your Primary Care Physician (PCP) before you can be seen by an ophthalmologist/optometrist? **Y N**

- **Do we have permission to**:
  - Send a recall appointment reminder to your home **Y N**
  - Leave appointment, billing or treatment information on your voice mail, phone via text message or e-mail **Y N**
  - I give permission to share appointment, billing or treatment information with the person named below:

  Name: ____

- **Refraction(s)** – I understand that a portion of my examination is not covered by Medicare/Most Insurance Plans and does not include this as of your integral exam (Refraction is $60.00)

- **Agreement as to Resolution of Concerns**
- **HIPAA Notice of Privacy Practice -** Disclosures of Protected Health Information

Print Name: ____

Signature: ____

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LASIK Screening Questionnaire

Do you have trouble seeing far away or up close? ____

How long has your prescription been stable? ____

Do you wear contact lenses? Y N If YES, date last worn: ______________________________________

What problems are you experiencing with your glasses and/or contacts? ____________________________

How long have you been thinking about having LASIK? ____

What is your occupation? ____

What are your hobbies? ____

If you are a good candidate, how soon would you like to have the procedure? ______________________

What (if anything) in the past has stopped you from proceeding with LASIK? ______________________

Is there a chance you could be pregnant or nursing? Y N Are you planning to be pregnant within the next 6 months? Y N

OCULAR HISTORY

Y	N	Keratoconus
Y	N	Corneal Erosions or Ulcers
Y	N	Herpes Simplex Virus Keratitis
Y	N	Lazy Eye
Y	N	Dry Eyes
Y	N	Thyroid Eye Disease
Y	N	Lid Disease
Y	N	Glaucoma
Y	N	Macular Degeneration
Y	N	Cataract
Y	N	Retinal Tear or Detachment
Y	N	Surgery or Injury to the Eye
Y	N	Radiation Therapy

Other: ________________________________

SYSTEMIC HISTORY

Y	N	Auto Immune Disorder
Y	N	Imitrex (sumatriptan) Use
Y	N	Cordarone (Amiodarone) Use
Y	N	Accutane (Isotretinoin)
Y	N	Diabetes
Y	N	Psoriasis
Y	N	Eczema
Y	N	Organ Transplant

What I am looking for in LASIK/PRK with Newsom Eye (Please rate these in order of most important 1 to 6)

Financing ___
Facility ___
Technology ___
Experience and Reputation of Surgeon ___
Cost ___
Results ___

All of the above information is true and accurate to the best of my knowledge. I understand that this is a preliminary screening and does not constitute a true eye exam. Further examination is required to ensure that I am a candidate for Refractive Surgery.

Patient Signature: ____________________________________ **Date:** ____________________

Parental Consent for Treatment & Care of Minors

I, ____, the parent and/or legal Guardian
Print Name
of the minor age child, ____________________________________ _______________
Print Name Date of Birth
Hereby give consent for medical necessary treatment and care, including emergency treatment and prescription of medicinal drugs, by the health care providers affiliated with Newsom Eye and Laser Center. In the event I am not available at a time this minor requires medical care, I give parties listed below the authority to seek and authorize care.

____ _______________________
Signature of Parent/Legal Guardian Date

____
Print Name of Parent/Legal Guardian

Alternate Parties Authorized to Seek Medical Care for Minor Child

1) ____ _______________________
Print Name Relationship

Phone: __________________________

2) ____ _______________________
Print Name Relationship

Phone: __________________________

3) ____ _______________________
Print Name Relationship

Phone: __________________________